Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

USMD HOSPITAL AT ARLINGTON
801 WEST INTERSTATE 20
ARLINGTON TX 76017

Carrier's Austin Representative Box
54

MFDR Date Received
JUNE 24, 2008

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-08-6346-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated June 24, 2008: "Claim meets the stop loss."

Requestor's Supplemental Position Summary Dated September 7, 2011:

"Review of the above referenced case shows unusually costly and extensive services were provided as evidenced by:

H & P:

38 yr old female- Pt status post-op right L5-S1 laminectomy discectomy who developed recurrent low back and bilateral leg pain while undergoing work hardening. ….Pt. admitted for decompression and fusion due to improve with conservative therapy.

Surgical Procedures:

1. Bilateral L5-S1 re-exploration of lumbar laminectomy.
2. Excision of recurrent L5-S1 disk protrusion.
3. Total right L5-S1 facetectomy, partial left L5-S1 facetectomy, and bilateral L5-S1 lateral recess decompression.
4. Transformaninal Lumbar Interbody Fusion (TLIF) L4-5 with autograft bone from right iliac crest.
5. Transformaninal Lumbar Interbody Fusion (TLIF) L5-S1 with autograft bone from right iliac crest.
6. Placement of Pioneer Peek Interbody Fusion cage L4-5.
7. Placement of Pioneer Peek Interbody Fusion Cage L5-S1
8. Posterior instrumentation of the lumbar spine, L4, L5 and S1, with Pioneer Quantum Pedicle screws (6) and rods (2).
9. Preparation of posterior element bone used for lumbar fusion
10. Bone marrow harvest
11. Right iliac crest reconstruction
12. Fluoroscopic localization and Guidance

Total cost of Implants: $89360

Post-operative Course:
Pre-op symptoms resolved, ambulated in hall and out of bed as tolerated. Discharged home PO Day 2.

Amount in Dispute: $26,722.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated July 7, 2008: "In this dispute, the requestor has not provided any additional information to justify the required services were unusually costly or unusually extensive."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
February 12, 2008 through February 14, 2008	Inpatient Hospital Services	$26,722.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1, 33 *Texas Register* 428, effective January 17, 2008, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits

- CAC-W1 – Workers Compensation state fee schedule adjustment.
- CAC-W4 – No additional reimbursement allowed after review of appeal/reconsideration.
- CAC-217-Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. (Note to be used for workers' compensation only).
- CAC-97- Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated this change to be effective 04/01/2008.
- 426- Reduced to fair and reasonable.
- 480 - Reimbursement based on the acute care inpatient hospital fee guidelines.
- 730 - Denied as included in per diem rate.
- 891 - The insurance company is reducing or denying payment after reconsideration.

Issues

1. Did the audited charges exceed $40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $138,475.80. The Division concludes that the total audited charges exceed $40,000.
2. 28 Texas Administrative Code §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The Third Court of Appeals' November 13, 2008 opinion states that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services" and further states that "…independent reimbursement under the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor in its original position statement states that "Claim meets the stop loss." This statement does not meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C) because the requestor presumes that the disputed services meet Stop-Loss, thereby presuming that the admission was unusually extensive. In it's supplemental position statement, the requestor asserts that: "Review of the above referenced case shows unusually costly and extensive services were provided as evidenced by: H & P... Surgical Procedures...Post-operative Course." The requestor's supplemental position fails to meet the requirements of §134.401(c)(2)(C) because the requestor does not demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(2)(C).
3. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. Neither the requestor's original nor it's supplemental position statement address how this inpatient admission was unusually costly. The requestor does not provide a reasonable comparison between the cost associated with this admission when compared to similar spinal surgery services or admissions, thereby failing to demonstrate that the admission in dispute was unusually costly. The division concludes that the requestor failed to meet the requirements of 28 Texas Administrative Code §134.401(c)(6).
4. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was two days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of two days results in an allowable amount of $2,236.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
- A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $89,360.00.
- The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
B-TCP 30cc Vial	1	$900.00	$990.00
Screw, Polyaxial 6.5x25mm	2	$1,225.00/each	$2695.00
Cage T-Plus VBR 7mm #30-T-1027	1	$5,890.00	$6479.00
Cage VBR T-Plus 10x27x12mm	1	$5,890.00	$6479.00
Rod 5.5x60mm 10-55-RR-60	2	$325.00/each	$715.00
Cap Locking Quantum	6	$305.00/each	$2013.00
Screw, Polyaxial Pedicl 6.75x30	2	$1,225.00/each	$2695.00
Screw, Polyaxial Pedicl 6.75x40	2	$1,225.00/each	$2695.00
TOTAL	17		$24,761.00

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- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed $714.70/unit for Thrombin vial. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is $26,997.00. The respondent issued payment in the amount of $26,997.00. Based upon the documentation submitted no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		10/4/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		10/4/2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.